# NSABP PROTOCOL B-40: REGISTRATION FORM

*Refer to Patient Entry Guidelines in the Members' Area of the NSABP Web site.*



**Patient Initials** [ ] , [ ] [ ] *Last First Middle*

8 0 [ ] [ ] [ ] [ ] [ ] [ ] [ ] **NSABP Patient ID**

**Institution/Affiliate** _____

_____

**Physician of Record** _____

(*Physician to whom drug will be sent must have a valid FDA Number.*)

**Date Informed Consent Signed**

[ ][ ] [ ][ ] [ ][ ][ ][ ]
Month Day Year

**Person Completing Form**

**Last Name:** _____ **First Name:** _____

**Phone:** ( ) -

**Fax:** ( ) -

**Patient Birth Date** [ ][ ] [ ][ ] [ ][ ][ ][ ]
Month Day Year

**Patient Social Security Number (USA only)** [ ][ ][ ] [ ][ ] [ ][ ][ ][ ]

**Race** (*more than one may be marked*)

- ○ White
- ○ Black or African American
- ○ Native Hawaiian or Other Pacific Islander
- ○ Asian
- ○ American Indian or Alaska Native
- ○ Unknown

**Method of Payment** (*mark primary method only*)

- ○ Private Insurance
- ○ Medicare
- ○ Medicare and Private Insurance
- ○ Medicaid
- ○ Medicaid and Medicare
- ○ Other
- ○ Military or Veterans Sponsored NOS
- ○ Military Sponsored (including CHAMPUS & TRICARE)
- ○ Veterans Sponsored
- ○ Self pay (no insurance)
- ○ No means of payment (no insurance)
- ○ Unknown

**Ethnicity**

- ○ Hispanic or Latino
- ○ Not Hispanic or Latino
- ○ Unknown

**Country of Residence**

- ○ US (USA)
- ○ CA (Canada)
- ○ PR (Puerto Rico)
- ○ Other _____

**Patient Zip Code (USA)** [ ][ ][ ][ ][ ]

**How did the patient answer the following questions on the consent form?** *(circle answers)*

1. **Yes No** I agree to have blood samples collected three times during this study. (These samples will be sent to the NSABP.)
2. **Yes No** My study doctor (or someone he or she chooses) may contact me in the future to ask me to take part in more research.

**Patient Height (cm)** [ ][ ][ ]

**Patient Weight (kg)** [ ][ ][ ] . [ ]

## Stratification Factors

**Clinical Tumor Size (Breast)**
*This measurement must be reported on the line for **"Target Lesion Number 1"** on page 2 of this form.*

**Lymph Node Involvement**
- ○ Clinically Negative
- ○ Clinically Positive

**Receptor Status**
- ○ ER-positive and/or PgR-positive
- ○ ER and PgR negative

**Age**
*Will be calculated from date of birth.*

**Certification of Eligibility:**
*Complete the Eligibility Checklist. This checklist will be reviewed at the time of audit.*

**In the opinion of the investigator, is the patient eligible?**
○ Yes ○ No

**Has the patient authorized the release of Protected Health Information to the NSABP?**
○ Yes ○ No



*Mark Circles Like This:* → ●